Ahmadi & Alvand, DDS, PA

General, Cosmetic and Implant Dentistry

PATIENT INFORMATION

Full Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip code _____

Home Phone Number _____ Work _____Cell phone _____

Language _____Sex _____ Marital Status: Single Married Divorced Separated Widowed

Date of Birth _____Age_____ Social Security _____Driver License _____

Email Address _____

Emergency Contact _____ Relation_____ Phone # _____

PARENT/GUARDIAN INFORMATION

Person Responsible for Patient (If different from above):_____

Relationship to Patient_____

Date of Birth _____Age_____ Social Security _____Driver License _____

Address _____ City _____ State _____ Zip code _____

Home Phone Number _____ Work _____Cell phone _____

Pharmacy Information
Name: _____
Address: _____
City: _____
Phone Number: _____

How did you hear about us?
- ☐ Patient: _____
- ☐ Insurance Company
- ☐ Internet
- ☐ Drive By/Walk By
- ☐ Facebook
- ☐ Other:_____

BILLING INFORMATION

- ☐ I do not have dental insurance
- ☐ I have dental insurance
  Insurance Company: _____
- ☐ I would like to be apply for a payment plan option (Care Credit)

Our office only files primary insurance, if you have any additional insurance, please notify our staff.
As a courtesy we are always happy to assist you in understanding your insurance benefits, as well as submitting your claim**. Please understand your insurance is a contract between you, your employer and / or your insurance company.**

We accept assigned payments from most insurance companies. However, co-pays and coinsurances are expected before services are rendered. If payment is not received from your insurance carrier within forty-five (45) days we will notify you. Failure of your insurance carrier to reimburse our office within sixty (60) days will result in billing you directly for the remaining balance. Keep in mind that on major or extensive procedures a nonrefundable deposit may be required at the time the appointment is scheduled.

I authorized CAPITAL DENTAL CARE to release any medical, dental, or any other information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original. I request payment of insurance benefits be made directly to CAPITAL DENTAL CARE. I am responsible for the deductibles, percentages, and non-covered services (as determined by my insurance). I understand that this office only uses composite (tooth colored) filling material and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.

_____ _____ _____

Patient Name (Please Print) Patient/Parent or Legal Guardian Signature Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions.
Due to certain medical conditions/medication; a medical clearance may be needed before dental treatment can be performed.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____
Are you on blood thinner medication?	Yes	No	

Women: Are you

Pregnant?	Yes	No	**Trying to get pregnant?**	Yes	No
Nursing?	Yes	No	**Taking oral contraceptives?**	Yes	No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors of Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
									Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

Dental History (Please circle yes or no)

When was the last time you visited the dentist? _____ Where? _____ When was your last cleaning? _____

Have you ever had periodontal (gum) treatment?	Yes	No
Do your gums bleed when you floss?	Yes	No
Do you need to be pre-medicated with antibiotics before treatment?	Yes	No

Do you have a bad dental experience? Yes No If yes, please explain: _____

_____

Do you have pain or concerns? ○ Yes ○ No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Capital Dental Care
Authorization for Release of Information

Patient Name: _____ Date of Birth: _____
FIRST NAME LAST NAME

CAPITAL DENTAL CARE is authorized to release protected health information to the entities named below. The purpose is to inform the patient or others in keeping with patient's instruction.
I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as describe in this document. I understand that a revocation is not effective in case where the information has already been disclosed but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
This authorization shall be in effect until revoked by patient.

Entity to Receive Information. (Check/write each person or entity that you approve to receive information).	**Description of Information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voicemail	☐ Results of lab test, x-rays and reports ☐ Account, including financial information
☐ Other (Provide Name and Relation to Patient) _____ _____ _____	☐ Results of lab test, x-rays and reports ☐ Account, including financial information
☐ None of the above	

Patient information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as describe in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____ _____
Signature of patient or Personal Representative Relation Date

Photographic Media Release Form
Pictures may be taken of you during the course of your treatment by Capital Dental Care. We would like to know if you authorize us to utilize your photographs on our website, Facebook or as a presentation for educational purposes. You understand that you are waiving any and all rights you may have as a patient to refuse this permission at a later date or to prohibit their use in future publications and/ or presentations.

Initials
I _____ allow Capital Dental Care all rights and access to pictures of my teeth either before, after or during treatment. Selecting this option releases any and all rights to these photos. I understand that by releasing the rights to said images, I have no future claim (monetary or otherwise) upon the release of my images.

I_____ DO NOT AGREE TO HAVE ANY PHOTOS OR IMAGES FOR ANY PURPOSE OTHER THAN THE CLINICAL CONSIDERATION OR CONSULTATION REGARDING MY INDIVIDUAL DENTAL TREATMENT.

_____ _____ _____
Signature of patient or Personal Representative Relation Date

Capital Dental Care

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____

Capital Dental Care

Ahmadi & Alvand, DDS, PA

Office Financial Policy

Thank you for selecting us for your dental care. We are focused on the success and completion of your dental treatment; with this in mind please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we request you read and sign.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, VISA, MASTERCARD, DISCORY AND AMERICAN EXPRESSS
*WE OFFER AFFORDABLE FINANCING OPTIONS FOR TREATMENT.
(See our receptionist for details)

Regarding your Insurance

We are in network with many insurance companies and accept assigned payments from most insurance companies. However, co-pays and coinsurances are collected according to your plan and are due before treatment is performed.

If we do not participate with your insurance network, we will submit your dental claim as a courtesy to you. Be aware that your insurance company may pay at a higher rate or downgrade certain services. You will be responsible for the unpaid portion your insurance did not cover.

You are responsible for any unpaid portion expected from your insurance; this amount will need to be collected on your next appointment.

If for any reason your account is turned over to a collection agency, you will be responsible for any and all fees associated to collect your balance.

Regarding Deposits for Appointments

For certain extensive appointments, a nonrefundable deposit may be required at the time the appointment is scheduled and a 48 hours cancellation notice is required for extensive appointments.

Regarding Missed Appointments

When we schedule an appointment, that time is reserved just for you. If this time does not longer fit in your schedule please give us at least 24 hours notice to move or cancel your appointment. As a courtesy to you we make every effort possible to verify your appointment in advance. Please help us serve you better by keeping scheduled appointments.

To provide the best care possible to all of our patients, *children are not allowed to be in the treating room, unless they have an appointment scheduled on the same day*. (If you arrive with a child, a responsible caregiver will need to be present in the waiting room to care for them) Our office is not responsible for the care of unsupervised children while in the building.

If a patient is under 18 years of age we required a parent or caregiver to remain in the building for the entire appointment.

Medicaid Patients

In you have Medicaid in order to be seen, we need your picture ID and your current Medicaid card. If you are 21 years of age or older, a $3.00 co-pay cash is due on each appointment.

If you child has Medicaid we need the parents picture ID and the current Medicaid card in order to be seen.

_____ _____ _____

Patient Name (Please Print) Patient/Parent or Legal Guardian Signature Date

Capital Dental Care
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer.

Gissella Long

Effective Date: September 1, 2007 **Revised: October 17, 2017**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.capitaldentalcare.net**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits

- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.
There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Gissella Long at 919-865-8300

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on September 1, 2007